MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05250 05241

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: EDWARD	Middle: JAMES	Last: BERRY	2a. DATE OF DEATH Month: 4 Day: 1 Year: 69	2b. HOUR: 6:00 M	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: 11/28/99	6. AGE (In years last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Md.			
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): plumber	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Baltimore Co	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: 7824 Eastern Avenue		
14. FATHER'S NAME First: JAMES	Middle: E.	Last: BERRY	15. MOTHER'S MAIDEN NAME First: MARY	Middle: C.	Last: McCABE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-54-7586-T	17. INFORMANT: Hospital records	Address			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hrs.
011.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b): Tuberculosis, minimal, inactive — yrs.
DUE TO, OR AS A CONSEQUENCE OF
(c): Generalized arteriosclerosis — yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Dementia praecox, hebephrenic type

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that ☒ (this hospital) attended the deceased from 8/14, 19 26, to 4/1, 19 69, that ☒ (we) last saw the deceased alive on 4/1 1969, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE: Moise Sucholeiki M.D.	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 4/1/69	
22d. PHYSICIAN'S NAME (Type): Moises Sucholeiki, M. D.	22e. ADDRESS: Springfield State Hospital		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-5-1969	23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn	23d. LOCATION (City or Town) (County) (State): Baltimore County, Maryland	
24. FUNERAL DIRECTOR: Lilly & Zeiler Inc.	ADDRESS: 1901-07 Eastern Ave.	25a. RECD BY REGISTRAR DATE: APR 3 1969	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

VR A15 (rev) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05251 05242

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
30M REV. 1/68

1. DECEASED-NAME (Type or print): First: George; Middle: HENRY; Last: Black Jr
2a. DATE OF DEATH: Month: APRIL; Day: 8; Year: 1969
2b. HOUR: 9:15A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MAY 2. 1912
6. AGE (In years last birthday): 56 YRS.
IF UNDER 1 YEAR: MONTHS; DAYS
IF UNDER 24 HRS.: HOURS; MIN
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Manchester
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): RD #1
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer
12b. KIND OF BUSINESS OR INDUSTRY: Agriculture
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Carroll
13c. CITY OR TOWN: Manchester
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: RD #1, Balto Pike
14. FATHER'S NAME: First: George; Middle: HENRY; Last: Black
15. MOTHER'S MAIDEN NAME: First: Virginia; Middle: ; Last: Myers
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 219-36-1094
17. INFORMANT: Gladys Black; Address: Manchester Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Suddenly
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary Heart Disease — Feb 1967
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While [ ] Not while [ ] at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Feb 4, 1967, to April 8, 1969, that (I) (we) last saw the deceased alive on March 14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joseph E Busa MD — DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 4/8/69
22d. PHYSICIAN'S NAME (Type): Joseph E. Busa MD
22e. ADDRESS: HAMPSTEAD Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4/11/69
23c. NAME OF CEMETERY OR CREMATORY: Manchester Cemetery
23d. LOCATION (City or Town) (County) (State): Manchester by Carroll Co

24. FUNERAL DIRECTOR: Wayne V. Kennedy — ADDRESS: Hanover, Penna
25a. REC'D BY REGISTRAR DATE: APR 14 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05252 05243

1. DECEASED-NAME (Type or print): First Homer Middle Alonzo Last BLACK
2a. DATE OF DEATH: Month April Day 19 Year 1969
2b. HOUR: 3:30 p.m.
3. SEX: male
4. RACE: white
5. DATE OF BIRTH: 11-23-02
6. AGE (In years last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: Mt. Savage
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET AND NUMBER: Route #1, Box 83
14. FATHER'S NAME First Newton S. Middle Last Black
15. MOTHER'S MAIDEN NAME First Rettie Middle Parks Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16b. SOCIAL SECURITY NO.: 215-10-1278
17. INFORMANT: Records Address: Springfield State Hospital, Sykesville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Fibro-granular Pulmonary Tuberculosis
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Tuberculous Pericarditis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 011.9
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years mos. or years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CBS assoc. with disturbance of metabolism, growth or nutrition, presenile brain disease, without qualifying phrase.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [X] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 7-25-67, 19____, to 4-19-69, 19____, that (I) (we) last saw the deceased alive on 4-19-69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dr. Antonius Glahn DEGREE ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. DATE SIGNED: 4-19-69
22d. PHYSICIAN'S NAME (Type): Antonius Glahn, M.D.
22e. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4-19-69
23c. NAME OF CEMETERY OR CREMATORY: St. George Cemetery
23d. LOCATION (City or Town) (County) (State): Mt. Savage, Md.
24. FUNERAL DIRECTOR ADDRESS: Joseph R. Durst, Frostburg, Md. 21532
25a. REC'D BY REGISTRAR DATE: APR 24 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4/68
45M - 1/69

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05253 — 05244

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print): First ALICE Middle MARIE Last BOSLEY
2a. DATE OF DEATH: Month April Day 14 Year 1969
2b. HOUR: 11P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: JAN 17, 1897
6. AGE (In years last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Manchester.
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Long View Nursing Home 128 E. Main Street
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Carroll
13c. CITY OR TOWN: Finksburg.
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: RFD #1
14. FATHER'S NAME: First JAMES Middle Last TAYLOR
15. MOTHER'S MAIDEN NAME: First Maggie Middle Curtis Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16b. SOCIAL SECURITY NO.: 213-05-1257A
17. INFORMANT: Mrs. Gladys WALTER Address: Reisterstown MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hour
4122
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis Generalized

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Oct 8, 1968, to April 14, 1969, that (I) (we) last saw the deceased alive on April 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Joseph E. Bush DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: April 14, 1969
22d. PHYSICIAN'S NAME (Type): Joseph E. Bush MD
22e. ADDRESS: Manchester, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: April 17, 69
23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove
23d. LOCATION (City or Town) (County) (State): Boring, Md.

24. FUNERAL DIRECTOR: J. T. Eline & Sons ADDRESS: Reisterstown, Md.
25a. REC'D BY REGISTRAR DATE: APR 16 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05254 05245

1. DECEASED-NAME (Type or print)	First: BIRDIE	Middle: G.	Last: BRASHEARS	2a. DATE OF DEATH Month: April Day: 28 Year: 1969	2b. HOUR: 1745 P M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Nov. 1, 1880	6. AGE (In years last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.			
10. CITY OR TOWN OF DEATH: New Windsor	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R.D. 2	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: New Windsor	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R.D. 2		
14. FATHER'S NAME First: Evan	Middle:	Last: Aldridge	15. MOTHER'S MAIDEN NAME First: Ellen	Middle:	Last: Eury	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: Alton R. Brashears	Address: Rt. 2 Union Bridge, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebrovascular accident

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral thrombosis.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 months

4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Nov 5, 1965, to Now, 19____, that (I) (we) last saw the deceased alive on April 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: J. H. Caricofe MD DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: April 28, 69

22d. PHYSICIAN'S NAME (Type): J. H. CARICOFE MD

22e. ADDRESS: Union Bridge, Md 21791

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/1/1969	Linganore Cemetery	Unionville, Frederick, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. M. Waltz,	Box 241, Sykesville, Md.	MAY 1 1969	Clerk of Circuit Court

1

05255

Item6 Film G411 4/21/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05246

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Ned	Middle: CADLE	Last: BROOKS	2a. DATE OF DEATH Month: 4 Day: 13 Year: 1969	2b. HOUR: 11A M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 8-13-1901	6. AGE (In years last birthday): 67 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Missouri	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Md		
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Correspondent-Commentator	12b. KIND OF BUSINESS OR INDUSTRY: NEWS		
13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Chevy Chase	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: 4103 Oliver Street	
14. FATHER'S NAME First: John	Middle: B.	Last: Brooks	15. MOTHER'S MAIDEN NAME First: Jane	Middle: —	Last: Cadle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 578072159	17. INFORMANT: Hospital record	Address		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Toxemia secondary to infected decubitus — days.

DUE TO, OR AS A CONSEQUENCE OF (c): Presenile dementia

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CVSS with circulatory disturbance other than arteriosclerosis without qualifying phrase

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 5-25, 1968, to 4-13, 1969, that (I) (we) last saw the deceased alive on 4-13 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death

22b. SIGNATURE: Suha Ozgun	DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☑	22c. DATE SIGNED: 4-13-1969	
22d. PHYSICIAN'S NAME (Type): SUHA OZGUN	22e. ADDRESS: Springfield State Hospital.		

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION	23b. DATE: 4/14/69	23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREM.	23d. LOCATION (City or Town): SUITLAND	(County): MD. (State)
24. FUNERAL DIRECTOR ADDRESS: J.S. GAWLER'S SONS, 5130 WIS. AVE., N.W. WASH. D.C.	25a. RECD BY REGISTRAR DATE: APR 15 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge		

VR A15 M
45M - 1-69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05256 — 05241

1 DECEASED NAME (Type or Print): First LESLIE Middle JENNINGS Last BROWN

2a DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month 4 Day 15 Year 1969 — 2b HOUR 2:50 P.M.

3 SEX: MALE — 4 RACE: WHITE — 5 DATE OF BIRTH: JAN. 8, 1908 — 6 AGE (In years on birthday) 61 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN

2c DATE PRONOUNCED DEAD: Month 4 Day 15 Year 1969 — 2d HOUR 3:00 P.M.

7a BIRTHPLACE (State or foreign country): MARYLAND — 7b CITIZEN OF WHAT COUNTRY? U.S.A. — 8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] — 9 COUNTY OF DEATH: CARROLL Co. Md

10 CITY OR TOWN OF DEATH: WESTMINSTER — 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): REAR 105 E. MAIN ST. — 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): CARPENTER — 12b KIND OF BUSINESS OR INDUSTRY

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND — 13b COUNTY: CARROLL — 13c CITY OR TOWN: WESTMINSTER — 13d INSIDE CITY LIMITS? YES [X] NO [ ] — 13e STREET AND NUMBER: REAR, 105 E. MAIN ST.

14. FATHER'S NAME First MILTON Middle SEYMOUR Last BROWN — 15 MOTHER'S MAIDEN NAME First FANNIE Middle M. Last SPENCER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) YES — (If yes give war or dates of service) W.W. II — 16b SOCIAL SECURITY NO 216-01-9982 — 17 INFORMANT: MRS. DORIS H. BROWN — ADDRESS REAR 105 E. MAIN ST. WESTMINSTER MD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH — 21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19 — 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) — 21f LOCATION Street or R.F.D. No. City or Town County State

22a **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Wplenn Spicher — CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type) — ADDRESS (Street or R.F.D. No.) 37 S. Main, Westminster, Carroll (County) Md.

22b DATE SIGNED 4-15-69

23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL — 23b DATE 4/18/69 — 23c NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEMETERY — 23d LOCATION (City or Town) (County) RURAL WESTMINSTER, MD.

24 FUNERAL DIRECTOR: C. S. Myers Jr. — ADDRESS Westminster, Md. 21157 — 25a REC'D BY REGISTRAR APR 21 1969 — 25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
10M REV 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05257

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05248

1. DECEASED NAME (Type or Print) First: DARE	Middle: S	Last: BUCHANAN	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month: 4 Day: 24 Year: 1969	2b. HOUR: 12:20 P M				
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 3-13-10	6. AGE (In years last birthday): 59 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month: 4 Day: 24 Year: 1969	2d. HOUR: 12:45 P M	
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.					
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): none	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Baltimore	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 2615 Hilton St., Baltimore				
14. FATHER'S NAME First: Andrew	Middle: G.	Last: Buchanan	15. MOTHER'S MAIDEN NAME First: Carrie	Middle: M.	Last: Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Records, Springfield State Hospital, Sykesvil						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days or wks.

423X

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b): old myocardial infarction — years

DUE TO, OR AS A CONSEQUENCE OF

(c): adhesive constrictive pericarditis — months or years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Epileptic psychosis.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Lewis Speicher M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street or city, town, or county): 955 Maiden Choice Lane Catonsville Md.

22b. DATE SIGNED: 4-24-69

23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	5.2.69	U. of Md., Med School	BALTIMORE, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hurd Funeral Home Sykesville Md.	MAY 5 1969	Florence Yingling

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05258 05230

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
May	Coulbourn		April 20 1969	5:35 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	Sept. 14, 1887	81 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	USA	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Carroll Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westminister	Carroll County Hosp.	Housewife	Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Carroll	Finksburg	YES ☐ NO ☒	Rt # 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles H.		Ashem	Mary		Wilson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
No	NO	220.12.8748	Thomas Coulbourn	1119 Daniels Ave. (7)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiac arrest

4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from April 17, 1969, to April 20, 1969, that (I) (we) last saw the deceased alive on April 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John S. Harsheyd	MD	☒	☐	☐	4/22/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JOHN S. HARSHEY M.D.	8 Anchor St. Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/23/69	Lorraine Park	Woodlawn Baltimore Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECEIVED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John T. Stansbury 6411 Windsor Mill Rd.	APR 23 1969	Marshall Dodge

1

05259

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05251

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1X68

1. DECEASED-NAME (Type or print): First: William Middle: Scott Last: Dayhoff
2a. DATE OF DEATH: Month: April Day: 29 Year: 1969
2b. HOUR: 815 A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 11-30-1890
6. AGE (In years last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Carroll Md
10. CITY OR TOWN OF DEATH: Uniontown
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rural
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Edge Setter - Shoe Mfg.
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland
13b. COUNTY: Carroll
13c. CITY OR TOWN: Uniontown
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: Rural
14. FATHER'S NAME First: Benjamin Middle: Dayhoff Last:
15. MOTHER'S MAIDEN NAME First: Laura Middle: Magee Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (If yes give war or dates of service): Yes WW I
16b. SOCIAL SECURITY NO: 213-05-1586
17. INFORMANT: Deborah B. Dayhoff Address: Uniontown Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial infarct (acute)
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerosis (chr)
DUE TO, OR AS A CONSEQUENCE OF (c): Benign tumor Rt foot
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): none

19a. DATE OF OPERATION: 3-10-69
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Benign tumor Rt foot
20a. AUTOPSY? YES [ ] NO [X]
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from Nov - 7, 19 69, to 4-25-, 19 69, that (I) (~~we~~) last saw the deceased alive on 3-25- 19 69, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Wm C. Jennette M.D. DEGREE — ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 4-29-69
22d. PHYSICIAN'S NAME (Type): Wm C. Jennette M.D.
22e ADDRESS: 103 E Main Westminster Md 21157

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5-2-1969
23c. NAME OF CEMETERY OR CREMATORY: Lutheran Cem.
23d. LOCATION (City or Town) (County) (State): Uniontown Md
24. FUNERAL DIRECTOR: W. Hubert Stone & Sons ADDRESS: New Windsor Md
25a. RECD BY REGISTRAR DATE: MAY 1 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05260 05252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: BESSIE	Middle: CATHERINE	Last: EBBERT	2a. DATE OF DEATH Month: apr Day: 1 Year: 1969
2b. HOUR: 11 36 AM			
3. SEX: F	4. RACE: W	5. DATE OF BIRTH: SEPT 23, 1884	6. AGE (In years last birthday): 84 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Md
10. CITY OR TOWN OF DEATH: UNION BRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): E BROADWAY	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEKEEPER	12b KIND OF BUSINESS OR INDUSTRY: OWN HOME
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: CARROLL	13c. CITY OR TOWN: UNION BRIDGE	13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER: E BROADWAY
14 FATHER'S NAME First: ADAM	Middle	Last: RICKETTS	15. MOTHER'S MAIDEN NAME First: SARAL Middle	Last: GRIMES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b SOCIAL SECURITY NO.: UNKNOWN	17 INFORMANT: BETTY MONET Address: UNION BRIDGE MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic CVD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years
4124
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.	21f LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 1960, 19___, to 4/11/69, 19___, that (I) ~~(we)~~ last saw the deceased alive on 3/31/69 19___, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M.E. Robertson MD DEGREE	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c DATE SIGNED: 4/11/69	
22d. PHYSICIAN'S NAME (Type): M E ROBERTSON	22e. ADDRESS: NEW WINDSOR MD		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/4/69	23c. NAME OF CEMETERY OR CREMATORY: MT VIEW	23d LOCATION (City or Town): UNION BRIDGE	(County): (State): MD
24. FUNERAL DIRECTOR: D D Hartzler Sons	ADDRESS: Union Bridge	25a REC'D BY REGISTRAR DATE: APR 7 1969	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

VR A15 (4) 30M REV 1/68

1

05261

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05253

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-(4) 30M REV. 1/68

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
	Clara	Maude	Erb	Month April Day 27 Year 1969	8:45 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Female	White	December 1, 1881	87 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Taneytown	Route # 1	Housewife	None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Carroll	Taneytown	YES ☐ NO ☒	Route # 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William		Frounfelter	Mary	Catherine	Myers

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	217-28-6108D	William F. Erb	R # 1, Taneytown, Md. 21787

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Toxemia 2° to Extensive Metastatic Lympho-Sarcoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 mo

DUE TO, OR AS A CONSEQUENCE OF (b) Marked Emaciation — 8 mo

DUE TO, OR AS A CONSEQUENCE OF (c) Lympho-Sarcoma of Scalp, cranial Vault orbit, Sinuses — 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2001

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chemo Therapy of Lympho-Sarcoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
4/24/67	Biopsy	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 4/18, 19 67, to 4/27, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 3/27 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
E. Ambler Thompson MD					4/28/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. E. Ambler Thompson	322 East Balt. St. Taneytown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	April 29, 1969	Grace Reformed Cemetery	Taneytown Carroll, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C.O. Fuss & Son John M. Stiles	Taneytown, Md. 21787	APR 30 1969	Stanley Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05262 — 05254

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 Hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MERLE	ELIZABETH	FLORA	April	5	1969	6:40 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
F	W	MAY 2-1915	53 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		CARROLL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
UNION BRIDGE	ELGER ST.	HOUSEKEEPER	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	CARROLL	UNION BRIDGE	YES ☒ NO ☐	ELGER ST (NONE)

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CHARLES		EARNST	MINNIE		FOGLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
NO	216-30-3607	MUNCIE FLORA	UNION BRIDGE MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

4 1 2 1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Hypertensive cardiovascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Sept. 12, 1964, to now, 19____, that (I) (~~we~~) last saw the deceased alive on April 3, 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	M.D. DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
J. H. Caricofe					April 5, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
J. H. Caricofe, M.D.	Union Bridge, Maryland 21791

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	APRIL 8-1969	BEAVER DAM	UNION BRIDGE RURAL MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
D.D. Hutchison Sons	Union Bridge	APR 11 1969	Calvin L. Judge

VR A15 (4) 30M REV. 1/68

1

05263

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05255

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A1 (C)
30M REV. 1-68

1. DECEASED NAME (Type or print) First / Middle / Last	Charles B. Godman	2a. DATE OF DEATH Month / Day / Year	April 26 1969
2b. HOUR	1900 M		
3. SEX	Male	4. RACE	White
5. DATE OF BIRTH	May 17, 1879	6. AGE (In years last birthday)	89 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH	Carroll Md
10. CITY OR TOWN OF DEATH	Taneytown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	RD 7-M
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if not rec'd)	Machinist- Retired	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Carroll
13c. CITY OR TOWN	Taneytown	13d. INSIDE CITY LIMITS? YES / NO	NO [X]
13e. STREET AND NUMBER	RD 7-M		
14. FATHER'S NAME First / Middle / Last	John E. Godman	15. MOTHER'S MAIDEN NAME First / Middle / Last	? Renner
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	NO	(If yes give war or dates of service)	NO
16b. SOCIAL SECURITY NO	215-01-7860	17. INFORMANT Address	Muriel V. Holbrook Same as # 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown.
4123
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 1959, 19____, to Now, 19____, that (I) (~~we~~) last saw the deceased alive on April 25 1969, and that in (my) (~~our~~) opinian death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	J. H. Caricofe MD	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: April 26, 1969
22d. PHYSICIAN'S NAME (Type)	J. H. Caricofe M.D.	22e. ADDRESS	N. Main St. Extended Union Bridge Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	4/29/69	
23c. NAME OF CEMETERY OR CREMATORY	Mt Olivet	23d. LOCATION (City or Town) (County) (State)	Baltimore Maryland	
24. FUNERAL DIRECTOR	Jhon T. Stansbury	ADDRESS	6411 Windsor Mill Rd.	
25a. RECD BY REGISTRAR DATE	APR 28 1969	25b. REGISTRAR'S SIGNATURE		

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11) 45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05264 05256

1 DECEASED NAME (Type or print) First Middle Last: Lillian Hays Garrett GORRELL

2a. DATE OF DEATH Month Day Year: April 11, 1969

2b. HOUR: 6:15 P.M.

3 SEX: female

4. RACE: white

5 DATE OF BIRTH: 5-29-91

6 AGE (In years last birthday): 77 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS: HOURS / MIN

7a BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Carroll Md.

10 CITY OR TOWN OF DEATH: Sykesville

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hosp.

12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: -----

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland

13b COUNTY: Carroll

13c CITY OR TOWN: Westminster

13d INSIDE CITY LIMITS? YES [ ] NO [ ]

13e STREET AND NUMBER: Rt. xx 3 Box 320 A

14 FATHER'S NAME First Middle Last: William Garrett

15 MOTHER'S MAIDEN NAME First Middle Last: Sarah Knight

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16b SOCIAL SECURITY NO: UNKNOWN

17 INFORMANT: Redords Address: Springfield State Hospital, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Bronchopneumonia. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO, OR AS A CONSEQUENCE OF

(b): Heart failure.due to recent mycardial infarct. — days

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CBS assoc. with circulatory disturbance other than cerebral arteriosclerisis with psychotic reaction.

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [X] NO [ ]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f LOCATION Street or R.F.D. No City or Town County State

22a **I certify** that (I) (~~the hospital~~) attended the deceased from 9-12-62, 19____, to 4-11-69, 19____, that (I) (~~we~~) last saw the deceased alive on 4-11-69 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alfredo M Labrit DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS [X]

22c. DATE SIGNED: 4-11-1969

22d PHYSICIAN'S NAME (Type): Alfredo M. Labrit, M.D.

22e. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE: 4/15/69

23c NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial Pk

23d LOCATION (City or Town) (County) (State): Elkridge, Maryland

24. FUNERAL DIRECTOR: Singleton Funeral Home/Glen Burnie.Md. Robert P Ware

ADDRESS

25a. RECD BY REGISTRAR DATE: APR 14 1969

25b. REGISTRAR'S SIGNATURE: Clinton Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05265 05251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
OLIVER	R.	HARRISON	April 8 1969	5:30 P.M.

3 SEX	4. RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / M.N.
Male	White	Jan. 16, 1880	89 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Mt. Airy	507 N. Main St.	Retired-Farmer	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Carroll	Mt. Airy	YES ☒ NO ☐	507 N. Main St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Nimrod		Harrison	Sally		Watkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
No		220-09-7849	Morley W. Harrison	Same As #13.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 years

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ DR CONTR BUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 50, to April, 19 69, that (I) (we) last saw the deceased alive on April 7 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
W.B. Culwell	M.D.				April 8, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
W.B. Culwell	900 So. Main St Mt Airy Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/10/19 69	Pine Grove	Mt. Airy, Carroll, Md.

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
C. M. Waltz, Box 241, Sykesville, Md.	APR 10 1969	

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05266 05258

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Emma	Mae	Hecker	04	24	69	2:00 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
Female	White	04-1-87 88	81 88 YRS				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Virginia	Birth - U.S.A.		Carroll Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Baltimore City	Balto.	YES ☒ NO ☐	3510 Parklawn Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John		Bosserman	Katherine		Hess

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
no	unknown	Records, Springfield State Hospital,	Sykesville Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Perforation of left ventricular wall — Approximate interval between onset and death: Minutes

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction — Day to week

DUE TO, OR AS A CONSEQUENCE OF (c) Thrombosis of left coronary artery — Day to week

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11-20-62, 19__, to 4-24-69, 19__, that (I) (we) last saw the deceased alive on 4-24-69 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS ☒	22c. DATE SIGNED
Dr. Antonius Glahn					4/25/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Antonius Glahn, M. D.	Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/28/69	Baltimore	Baltimore, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REGISTRAR'S DATE	25b. REGISTRAR'S SIGNATURE
Leonard J Ruck Inc.	Baltimore, Maryland	APR 28 1969	

VR A15 14
45M - 1/69

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05267

CERTIFICATE OF DEATH

05259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
FREDERICK	RUTTER	JACKSON	April	6	1969	12:45 A M

3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
MALE	WHITE	JULY 15, 1886	82 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Phila Pa.	U.S.A.		CARROLL Co. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER	CARROLL Co. GEN. HOSP.	SALESMAN	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
MARYLAND	CARROLL	WESTMINSTER		601 OLD BALTO BLVD.

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ANDREW		JACKSON	HESTER		RUTTER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
NO	216-05-1309	MRS MARIAN B. REDMILE,	17 SHIRLEY RD NARBETH, PA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

		APPROX. MATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Bronchogenic Carcinoma	1 yr.
DUE TO OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Mar 30, 1969, to April 6, 1969, that (I) (we) last saw the deceased alive on April 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
John S. Harshey	M.D.				4/6/69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
JOHN S. HARSHEY M.D.	8 Anchor St. Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
BURIAL	4/10/69	WESTMINSTER CEMETERY	WESTMINSTER		MD.

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
L. S. Myers Jr.	Westminster, Md.	APR 10 1969	J Charles Jordan

VR A15 (4) 30M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05263 05260

1. DECEASED NAME (Type or print) First: FRANCIS	Middle: BERNARD	Last: JAWORSKI	2a. DATE OF DEATH Month: APRIL Day: 8, Year: 1969
2b. HOUR: 12:25 PM			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 9-4-01	6. AGE (In years last birthday): 67 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Poland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Lab technician	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived / if institution Residence before admission) STATE: Maryland	13b. COUNTY: Baltimore City	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 5331 Maple Ave.			
14. FATHER'S NAME First: Francis	Middle	Last: Jaworski	15. MOTHER'S MAIDEN NAME First: Unk. / Middle / Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: Unk.	17. INFORMANT: Records, Springfield State Hospital — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — APPROX. INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): CBS assoc. with cerebral arteriosclerosis, with psychotic reaction (Parkinson's signs).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 4-30-65, 19____, to 4-8-69, 19____, that (I) (we) last saw the deceased alive on 4-8-69, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death

22b. SIGNATURE: Octavio A Ruiz M.D. DEGREE — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X] — 22c. DATE SIGNED: 4-8-69

22d. PHYSICIAN'S NAME (Type): Octavio A. Ruiz, M. D. — 22e. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 12 APR 69	23c. NAME OF CEMETERY OR CREMATORY: St. Stanilaus Cemetery	23d. LOCATION (City or Town): Chicopee,	(County): Massachusetts (State)
24. FUNERAL DIRECTOR — ADDRESS: Starzyk Funeral Home 81 Center St. Chicopee, Mass.		25a. RECD BY REGISTRAR DATE: APR 14 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05269 — 05261

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (1) 30M REV. 1/68

1. DECEASED-NAME (Type or print) First: Louisa	Middle: J	Last: Jefferson	
2a. DATE OF DEATH: Month: April Day: 27, Year: 1969	2b. HOUR: 12:05 P.M.		
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Nov. 5, 1879	6. AGE (In years last birthday): 89 YRS. IF UNDER 1 YEAR: MONTHS, DAYS IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 7 Grandview Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Carroll	13c. CITY OR TOWN: Sykesville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET AND NUMBER: Grandview Ave
14. FATHER'S NAME First: John Middle: — Last: Eckert	15. MOTHER'S MAIDEN NAME First: Unk Middle: Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: —	17. INFORMANT: Mrs. Leona Burman	Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CEREBRAL VASCULAR ACCIDENT — C B A

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension, ASHD, Arteriosclerosis, generalized — 1967

DUE TO, OR AS A CONSEQUENCE OF (c): Bronchial pneumonia — 1969

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from ____, 1967, to April, 1969, that (I) (we) last saw the deceased alive on April 27 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Howard E. Hall M.D.	DEGREE: ATTENDING PHYS ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 4/28/69	
22d. PHYSICIAN'S NAME (Type): Howard E. Hall, M. D.	22e. ADDRESS: Sykesville, Maryland 21784		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-30-69	23c. NAME OF CEMETERY OR CREMATORY: Old Oakland Cemetery	23d. LOCATION (City or Town): Sykesville	(County)	(State): Md
24. FUNERAL DIRECTOR: Harry E. Wright	ADDRESS: Sykesville, Md.	25a. RECD BY REGISTRAR DATE: MAY 2 1969	25b. REGISTRAR'S SIGNATURE: [illegible] Judge		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05270 Item8 Film Gul3 6/20/69 kk

CERTIFICATE OF DEATH

05262

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Jesse	James	Jett	4 - 5 - 69	6:30 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	3/27/1900	69 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
Virginia	U.S.A.	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Carroll Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hosp.	Freight Conducter	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Howard	Ellicott City	YES ☐ NO ☐	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Carter	B.	Jett	Carrie		O'Sullivan

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	218-07-3029	Hospital Records - Sykesville, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE months

DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that ☒ (this hospital) attended the deceased from 3/12, 19 65, to 4/28 4/5 19 69, that (he/we) last saw the deceased alive on 4/5 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE: ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☑	22c DATE SIGNED
Gracito V. Patricio		4/5/69

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
GRACITO V. PATRICIO	

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	4-10-69	Good Shepherd	Ellicott City Howard Md

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Higinbotham-Slack	Ellicott City Md	APR 14 1969	Clerk or Judge

VR A15 (A)
30M REV 68

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05271 05263

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First MARTIN Middle JOSEPH Last KAVANAUGH IV
2a. DATE OF DEATH: Month APRIL Day 18 Year 69
2b. HOUR: 8:15 P.M.
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: SEPT-5, 1954
6. AGE (In years last birthday): 14 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS M.N
7a. BIRTHPLACE (State or foreign country): BALTO. MD.
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: CARROLL Co. MD. Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER RD#7
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Tyrone Road.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): STUDENT
12b. KIND OF BUSINESS OR INDUSTRY: —
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence Before admission) STATE: MD.
13b. COUNTY: CARROLL
13c. CITY OR TOWN: WESTMINSTER
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET AND NUMBER: TYRONE ROAD RD#7
14. FATHER'S NAME First MARTIN J. Middle KAVANAUGH Last III.
15. MOTHER'S MAIDEN NAME First DOROTHY Middle HENRY Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service): —
16b. SOCIAL SECURITY NO.: —
17. INFORMANT: MARTIN J. KAVANAUGH Address: WESTMINSTER RD#7 Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia Secondary to Convulsions
DUE TO, OR AS A CONSEQUENCE OF (b): Terminal Aspiration of Gastric Contents Terminal
DUE TO, OR AS A CONSEQUENCE OF (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Terminal

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Patient known to have generalized seizures 3½ years. Treatment under

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☑ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from Jul, 1967, to April, 1969, that (I) (we) last saw the deceased alive on 18 April 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dean Z. Griffin DEGREE: ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 19 April 69
22d. PHYSICIAN'S NAME (Type): DEAN Z. GRIFFIN
22e. ADDRESS: RIDGEROAD WESTMINSTER, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 4/21/69
23c. NAME OF CEMETERY OR CREMATORY: MEADOW BRANCH CEM.
23d. LOCATION (City or Town) (County) (State): WESTMINSTER RD. Md.
24. FUNERAL DIRECTOR: J. E. Rogers Jr. ADDRESS: Westminster, Md.
25a. RECEIVED BY REGISTRAR DATE: APR 21 1969
25b. REGISTRAR'S SIGNATURE: Beatrice Judge

VR A15 (4) 30M REV 11'68

1

05272

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05264

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First: ALMETA; Middle: NMN; Last: KOESEE
2a. DATE OF DEATH: Month: APRIL; Day: 7; Year: 1965
2b. HOUR: 1:40 A.M
3. SEX: FEMALE
4. RACE: NEGRO
5. DATE OF BIRTH: 8-3-30
6. AGE (In years last birthday): 38 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): D.C
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: CARROLL Md.
10. CITY OR TOWN OF DEATH: SYKESVILLE
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SPRINGFIELD STATE HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): DOMESTIC
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY:
13c. CITY OR TOWN: BALTIMORE
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 831 CENTRAL AVENUE.
14. FATHER'S NAME: First: EDWARD; Middle:; Last: ERVIS
15. MOTHER'S MAIDEN NAME: First: FLORENCE; Middle:; Last: CROWNER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 220-22-1722
17. INFORMANT: RECORDS, SPRINGFIELD STATE HOSPITAL Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pulmonary Tuberculosis, Far Advanced — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO, OR AS A CONSEQUENCE OF: Active
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes, Mellitus, Schizophrenia

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M P.M; Month; Day; Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 7-12-68, 19____, to 4-7-69, 19____, that (I) (we) last saw the deceased alive on 4-7-69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jose A. Raquel J. M.D — DEGREE: ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22c. DATE SIGNED: 4/7/69
22d. PHYSICIAN'S NAME (Type): Jose A. Raquel J. M.D
22e. ADDRESS: Springfield State Hosp

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 3-12-69 Burial
23c. NAME OF CEMETERY OR CREMATORY: MT CALVARY Cem
23d. LOCATION (City or town) (County) (State): Balto Md

24. FUNERAL DIRECTOR: Elroy O. Wilson, Sr. ADDRESS:
25a. REC'D BY REGISTRAR DATE: APR 14 1969
25b. REGISTRAR'S SIGNATURE: Charles Jones

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05273 — 05265

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Radie	Middle:	Last: Kelbaugh	2a. DATE OF DEATH: April Month 10, Day 1969 Yr.
2b. HOUR: 10:30 A.M.			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Sept. 9, 1873	6. AGE (In years last birthday): 95 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md
10. CITY OR TOWN OF DEATH: Silver Run	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Meadow View Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b. COUNTY: Balto.	13c. CITY OR TOWN: Upperco,	13d. INS OF CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: Old Hanover Rd.			
14. FATHER'S NAME First Middle Last: Alexander Marsh	15. MOTHER'S MAIDEN NAME First Middle Last: Rachael Ann Osborn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): NO	16b. SOCIAL SECURITY NO: 217-54-9826	17. INFORMANT: Mrs. George Osborn	Address: Upperco, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 MONTH
DUE TO, OR AS A CONSEQUENCE OF (b): Senility — 5 years
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (this hospital) attended the deceased from July 10, 1968, to April 10, 1969, that (I) (we) last saw the deceased alive on April 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Julius Chapkis	DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED: 4/11/69	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		

23a. BURIAL CREMATION, REMOVAL (Specify): Burial	23b. DATE: April 14, 1969	23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove Cem.	23d. LOCATION (City or Town): Upperco, Md.	(County) (State)
24. FUNERAL DIRECTOR: Tipton - Eline Funeral Home	ADDRESS: Hampstead, Md.	25a. REC'D BY REGISTRAR DATE: APR 15 1969	25b. REGISTRAR'S SIGNATURE: [illegible] Judge	

VR A15 M 45M 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05274

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05266

1 DECEASED NAME (Type or Print) First / Middle / Last	JOHN RAYMOND KELLEY	2a DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month / Day / Year	4-12 / 69	2b HOUR	5:30 P.M.
3. SEX	Male	4. RACE	White	5 DATE OF BIRTH	June 23,1891	6 AGE (In years last birthday)	77 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month / Day / Year	4 / 12 / 1969	2d HOUR	5:30 P.M.
7a BIRTHPLACE (State or foreign country)	Maryland	7b CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH	Carroll Md.
10. CITY OR TOWN OF DEATH	Mt. Airy	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	609 S. Main St.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	Lumber Yard Foreman	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	Maryland	13b COUNTY	Carroll	13c CITY OR TOWN	Mt. Airy	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER	609 S. Main St.
14 FATHER'S NAME First / Middle / Last	Jeremiah Franklin Kelley	15 MOTHER'S MAIDEN NAME First / Middle / Last	Margaret Burrall
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	214-03-5254	17 INFORMANT	Mrs Sadie I. Kelley,	ADDRESS Mt. Airy, Md. 609 S. Main St.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Shotgun Wound Left Chest — APPROX. MATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF (b) Self Inflicted

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 5:30 4/12 1969	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot Self in Chest with Shotgun
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home	21f LOCATION Street or R.F.D. No. 609 South Main	City or Town Mt Airy	County Carroll	State Md

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER: W. Glenn Speicher M.D.

EXAMINER'S NAME (Type): W. Glenn Speicher, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MED CAL EXAMINER [X]

ADDRESS (Street, City, Town or County): 135 E. Main Westminster Md.

22b. DATE SIGNED: 4-12-69

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)	
Burial	4/15/69	Pine Grove	Mt. Airy, Md.	
24. FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Olin L. Molesworth,	Damascus, Md.	APR 16 1969	Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05275

CERTIFICATE OF DEATH

05267

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
LEO	BERNARD	KERN	APRIL 18, 1969	8:45 A M

3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / M.N
Male	White	5-14-06	62 YRS		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
W. Va.	U.S.A.		Carroll Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Laborer	

13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Maryland	Washington	Harpers Ferry		Rural

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
George	R.	Kern	Daisy	Barbara	Merit

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT Address
No	236-14-8064	Records, Springfield State Hospital

MED.CAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia, right lung	Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Extensive interstitial hemorrhage in left thigh & left extraperitoneal abdominal area, probably due to	Days or Week
DUE TO, OR AS A CONSEQUENCE OF (c)	Ruptured thrombotic femoral & iliac vein	Days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 8-27-68, 19____, to 4-18-69, 19____, that (I) (we) last saw the deceased alive on 4-18-69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Octavio A. Ruiz	ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒	4-18-69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
Octavio A. Ruiz, M.D.	Springfield State Hospital Sykesville, Maryland 21784

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/21/69	Fairview Cemetery	Bolivar, Jefferson, W.Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Harry W. Haight F.H.	[redacted] E. Sykesville, Md.	DATE APR 22 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05276

CERTIFICATE OF DEATH

05268

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: DANIEL	Middle: FRANKLIN	Last: KIFER	2a. DATE OF DEATH Month: 4 Day: 23 Year: 69	2b. HOUR: 6:40 A M	
3 SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: 06/17/1896	6. AGE (In years last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md			
10 CITY OR TOWN OF DEATH: Sykesville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Coal Miner	12b. KIND OF BUSINESS OR INDUSTRY: Mining			
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE: Maryland	13b COUNTY: Garrett	13c CITY OR TOWN: Swanton	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET AND NUMBER: Rt. 1 Swanton, Md		
14 FATHER'S NAME First: David	Middle	Last: Kifer	15. MOTHER'S MAIDEN NAME First: Elizabeth	Middle	Last: Shipaway	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 236-01-8051A	17. INFORMANT: Hospital Records	Address		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CA of lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: mths

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis — yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

CBS associated with cerebral arteriosclerosis with psychotic reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that I (this hospital) attended the deceased from 2/19/ , 19 69 , to 4/23/ , 19 69 , that I (we) last saw the deceased alive on 4/23/ 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.

22b SIGNATURE: Suha Ozgun, M. D. DEGREE: ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED: 4/23/69		
22d. PHYSICIAN'S NAME (Type): Suha Ozgun, M. D.	22e. ADDRESS: Springfield State Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/26/69	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial	23d LOCATION (City or Town): Cumberland (County) Md. (State)
24 FUNERAL DIRECTOR: E. L. Beal	ADDRESS: Westernport, Md.	25a. REC'D BY REGISTRAR DATE: APR 25 1969	25b. REGISTRAR'S SIGNATURE:

VR A15 [illegible]
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05277 05269

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Pauline	Middle: --	Last: Kornke	2a. DATE OF DEATH Month: 4-22-69 Day Year	2b. HOUR: 6:30 A.M.
3. SEX: female	4. RACE: white	5. DATE OF BIRTH: 2-3-04	6. AGE (In years last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll County Md	
10. CITY OR TOWN OF DEATH: Sykesville, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield St. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Clerical work	12b. KIND OF BUSINESS OR INDUSTRY: clerical	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Balt. ~~City~~	13c. CITY OR TOWN: Balt. City	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 1 Maple Drive
14. FATHER'S NAME First: Theodore	Middle: --	Last: Kornke	15. MOTHER'S MAIDEN NAME First: Emma	Middle: --- Last: Kaschke
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: unk.	17. INFORMANT: Medical Records Address: Springfield State Hosp., Sykesville, M.D.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atherosclerosis of
DUE TO, OR AS A CONSEQUENCE OF (b): Multiple Duodenal ulcers.
DUE TO, OR AS A CONSEQUENCE OF (c):
707.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROX MATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Schizophrenia, Chronic, Simple Type.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D No. City or Town County State	

22a. I certify that ~~(I)~~ (this hospital) attended the deceased from 10-16-56, 19____, to 2-22, 19 69, that ~~(I)~~ (we) last saw the deceased alive on 2-22 19 69, and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~(I)~~ (we) (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: Chas. F. Sagisi M.D. DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22c. DATE SIGNED:

22d. PHYSICIAN'S NAME (Type): G. Sagisi, M.D. 22e. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-24-69	23c. NAME OF CEMETERY OR CREMATORY: Maryland Memorial	23d. LOCATION (City or Town): Baltimore	(County):	(State): Md
24. FUNERAL DIRECTOR: Kerr & Wright Inc.	ADDRESS: [illegible]	25a. REC'D BY REGISTRAR DATE: APR 25 1969	25b. REGISTRAR'S SIGNATURE: Deputy Judge		

VR A15 (4) 30M REV 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ME Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05278

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05270

1. DECEASED NAME (Type or Print) First: RUTH Middle: OTHELLO Last: LONG
2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: 4-3-69
2b. HOUR: 5:00 P M
2c. DATE PRONOUNCED DEAD Month 4 Day 3 Year 19 69
2d. HOUR: 5:25 P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Aug. 25,1909
6. AGE (in years last birthday): 59 YRS
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Carroll Md
10. CITY OR TOWN OF DEATH: Keymar
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Route # 1
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Bakery worker
12b. KIND OF BUSINESS OR INDUSTRY: Baking
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Carroll
13c. CITY OR TOWN: Keymar
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: Route # 1
14. FATHER'S NAME First: William Middle: Elias Last: Stitely
15. MOTHER'S MAIDEN NAME First: Maude Middle: XXXXX Last: Otto
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO: 216-05-0985
17. INFORMANT / ADDRESS: Mrs. Maude Stitely, R # 1 Keymar, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis (acute) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: W. Glenn Speicher M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22b. DATE SIGNED: 4-3-69
EXAMINER'S NAME (Type): W. Glenn Speicher
ADDRESS (Street, town, or county): 135 E Main Westminster Carroll

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Apr. 6, 1969
23c. NAME OF CEMETERY OR CREMATORY: Middleburg Cemetery
23d. LOCATION (City or Town) (County) (State): Middleburg, Carroll, Maryland
24. FUNERAL DIRECTOR: John H. Skiles — C.O.Fuss & Son
ADDRESS: Taneytown, Maryland
25a. REC'D BY REGISTRAR DATE: APR 7 1969
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05279 — 05271

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Harold	Middle: Seiss	Last: Mehring	2a. DATE OF DEATH Month: April	Day: 2,	Year: 1969	2b. HOUR: 4:20 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: November 7, 1892	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / M.N.		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md				
10. CITY OR TOWN OF DEATH: Taneytown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): E. Baltimore Street	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Livestock Broker	12b. KIND OF BUSINESS OR INDUSTRY: Cattle				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Taneytown	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: E. Baltimore Street			
14. FATHER'S NAME First: David	Middle: M.	Last: Mehring	15. MOTHER'S MAIDEN NAME First: Mary	Middle: E.	Last: Basehoar		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 215-34-1890	17. INFORMANT Address: Dr. Richard Mehring, Kensington, Md.					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Artery Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Few Min.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4[illegible]
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis — 1 year
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis — 10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R F D No.	City or Town	County / State

22a. I **certify** that (I) (this hospital) attended the deceased from 10/23, 1958, to 4/2, 1969, that (I) (~~we~~) last saw the deceased alive on 4/[illegible], 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: R. S. McVaugh M.D. DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 4/2/69	
22d. PHYSICIAN'S NAME (Type): R. S. McVaugh	22e. ADDRESS: Taneytown, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Apr. 5, 1969	23c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery	23d. LOCATION (City or Town) (County) (State): Taneytown, Carroll Co., Md.	
24. FUNERAL DIRECTOR: C.O. Fuss & Son	ADDRESS: John H. Stiles Taneytown, Maryland	25a. REC'D BY REGISTRAR DATE: APR 7 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05280 05272

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First James	Middle Saint Clare	Last MILLER	2a. DATE OF DEATH Month 4	Day 10	Year 69	2b. HOUR 5:20 PM
3. SEX Male	4. RACE Colored	5. DATE OF BIRTH 10-16-92	6. AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS 3 DAYS 10	IF UNDER 24 HRS. HOURS 5 MIN	
7a. BIRTHPLACE (State or foreign country) Dist Col	7b. CITIZEN OF WHAT COUNTRY? America	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH CARROLL Md.			
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield St. Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER 816 No. Fulton Ave		
14. FATHER'S NAME First Unknown	Middle JOHN	Last Miller	15. MOTHER'S MAIDEN NAME First Unknown	Middle LUCY ANN	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 212-10-1988	17. INFORMANT Hospital Records	Address Springfield St Hosp.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Coronary Disease

409

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Brain Syndrome associated with arteriosclerosis without qualifying phrase

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 1-2-, 19 69, to 3-10-, 19 69, that (I) (we) last saw the deceased alive on 3-10-, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED 4/10/69
22d. PHYSICIAN'S NAME (Type) J. C. Murphy, M. D.					22e. ADDRESS Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-14-1969	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet	23d. LOCATION (City or Town) Baltimore	(County)	(State)
24. FUNERAL DIRECTOR Mortuary Chapel	ADDRESS 635 W Fayette St	25a. RECD BY REGISTRAR DATE APR 14 1969	25b. REGISTRAR'S SIGNATURE [illegible]		

VR A15 45M 1-69

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05281

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05273

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Jacob	Middle: C	Last: Monath	2a. DATE OF DEATH: April (Month) 14 (Day) 1969 (Year)	2b. HOUR: 3:45 M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 1/24/1891	6. AGE (In years last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Pa	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.			
10. CITY OR TOWN OF DEATH: Manchester	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Fair View Nursing Home 1215 W Main St	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Machinist	12b. KIND OF BUSINESS OR INDUSTRY: Factory			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Lineboro	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER		
14. FATHER'S NAME First: George	Middle	Last: Monath	15. MOTHER'S MAIDEN NAME First: Lamanda	Middle	Last: Wildasin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: yes (If yes give war or dates of service): WW 1	16b. SOCIAL SECURITY NO: 214-03-6535	17. INFORMANT: Mrs Jacob Monath	Address: Lineboro Md			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hepatic Coma — Approx. interval between onset and death: 2 weeks

DUE TO, OR AS A CONSEQUENCE OF: Cancer carcinoma — 4 years

(b) Arteriosclerotic Heart Disease — 5 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 5'10

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pulmonary emphysema · Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Sept, 1967 to April 14, 1969, that (I) (we) last saw the deceased alive on March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
W. H Foard	M.D.	☑	☐	☐	4/14/69

22d. PHYSICIAN'S NAME (Type): W H Foard M D

22e. ADDRESS: Manchester, Md 21102

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	April 16, 1969	Lineboro Cemetery	Lineboro, Carroll Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tipton - Eline Funeral Home Hampstead, Md.	APR 16 1969	Charles Judge

VR A15 (4) 30M REV 9 68

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05282

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05274

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GEORGE	KOONTZ	MORELOCK	APRIL 7-1969	6:00 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	5-18-1881	87 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.	WIDOWED [X]	CARROLL Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of work life even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER	ROUTE 2	TRUCKER-FARMER-RET	

13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
MARYLAND	CARROLL	WESTMINSTER R.2	NO [X]	RURAL

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE		MORELOCK	LYDIA		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
No No	216-30-2809	MRS ADDIE B. COOK	WESTMINSTER MD ROUTE 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: about 4 years

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): none

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	NO [X]	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
		none	

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Apr. 7" 1965, to Apr. 7" 1969, that (I) (~~we~~) last saw the deceased alive on Apr. 5" 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
C. L. Billingslea M.D.	M.D.	[X]	☐	☐	4-9-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
C. L. Billingslea M.D.	Westminster, Md.

23a. BUR., CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	4-10-69	LEISTERS CEM.	WESTMINSTER, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
D. D. Hartter & Sons	Westminster, Md.	APR 11 1969	Deputy Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

05283

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05275

1 DECEASED NAME (Type or Print) First / Middle / Last	WALTER JACOB NEWMAN				2a DATE KNOWN ☒ OF ESTIMATED ☐ Month / Day / Year	4-22-1969	2b HOUR 10:10 A M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c DATE PRONOUNCED DEAD Month / Day / Year	2d HOURS
MALE	WHITE	JAN. 20, 1898	71 YRS			4 / 22 / 1969	10:15 A M
7a BIRTHPLACE (State or Foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH				
MARYLAND	U.S.A.		CARROLL CO. Md				
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b KIND OF BUSINESS OR INDUSTRY				
WESTMINSTER	CARROLL CO. GENERAL HOSP.	SALESMAN	LIQUOR STORE				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET AND NUMBER			
MARYLAND	CARROLL Co	WESTMINSTER		511 E. MAIN ST.			
14 FATHER'S NAME First / Middle / Last	NOAH C. NEWMAN		15 MOTHER'S MAIDEN NAME First / Middle / Last	MARY JANE KRUMRINE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS			
NO	—	217-03-4179	MRS. HELEN B. NEWMAN,	SAME ADDRESS			

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot Skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

DUE TO, OR AS A CONSEQUENCE OF: (b) Self Inflicted

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF: (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒	
21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)	
	4-22-1969	Shot Self in Head with 38 cal Pistol	
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street factory office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	
	Res Home	511 E main	Westminster Carroll Md

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wilson Speicher — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) — ADDRESS (Street and number or location) 13 E. Main Westminster, Carroll

22b. DATE SIGNED: 4-22-69

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County)	
BURIAL	4/25/69	WESTMINSTER CEM.	WESTMINSTER CARROLL	MD
24 FUNERAL DIRECTOR	ADDRESS	25a REGISTERED BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE	
J. E. Myers Jr.	Westminster, Md.	APR 25 1969		

VR A15ME (5) 10M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05284 — 05276

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First ELMER Middle EDWARD Last NUSBAUM
2a. DATE OF DEATH: Month April Day 25 Year 1969
2b. HOUR: 10-15 AM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: DEC. 15-1892
6. AGE (In years last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: CARROLL Md.
10. CITY OR TOWN OF DEATH: UNION BRIDGE
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): ELGER ST
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): OPERATOR
12b. KIND OF BUSINESS OR INDUSTRY: TAVERN
13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission): STATE MARYLAND
13b. COUNTY: CARROLL
13c. CITY OR TOWN: UNION BRIDGE
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: ELGER ST.
14. FATHER'S NAME: First SOLOMON Middle NUSBAUM Last
15. MOTHER'S MAIDEN NAME: First FANNIE Middle GARBER Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service): YES WORLD WAR I
16b. SOCIAL SECURITY NO: 216-05-3389
17. INFORMANT: ELSIE W. NUSBAUM — Address: UNION BRIDGE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): arteriosclerotic CVD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years
4124
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus, Ventral hernias

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 1949, 19____, to 4/25/69 19____, thot (I) ~~(we)~~ last saw the deceased alive on 4/23/69 19____, and thot in (my) ~~(our)~~ opinian death accurred on the date ond hour ond from the couses stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: M. E. Robertson MD — DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 4/25/69
22d. PHYSICIAN'S NAME (Type): M. E. ROBERTSON
22e. ADDRESS: New Windsor Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 4-28-69
23c. NAME OF CEMETERY OR CREMATORY: MT. VIEW CEM.
23d. LOCATION (City or Town) (County) (State): UNION BRIDGE MD.
24. FUNERAL DIRECTOR: D. V. Hauterstock
ADDRESS: UNION BRIDGE MD
25a. RECD BY REGISTRAR DATE: APR 28 1969
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4) 30M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

05285

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05277

1. DECEASED-NAME (Type or print) First: Sadie	Middle: Mae	Last: Putman	2a. DATE OF DEATH: April Month 4 Day 1969 Year	2b. HOUR: 11 A M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: May 14, 1886	6. AGE (In years last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Penna.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.		
10. CITY OR TOWN OF DEATH: Westminster	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Carroll Co. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Carroll	13c. CITY OR TOWN: Taneytown	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RD 1	
14. FATHER'S NAME First: John	Middle: Monroe	Last: Light	15. MOTHER'S MAIDEN NAME First: Amanda	Middle:	Last: Laymaster
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 212-24-3729D	17. INFORMANT: Mrs. Wilson Myers	Address: Taneytown, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4123
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Bronchopneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from April 2, 19 69, to April 4, 19 69, that (I) (we) last saw the deceased alive on April 4 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death

22b. SIGNATURE: John S. Harshey, M.D. DEGREE — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 4/4/69
22d. PHYSICIAN'S NAME (Type): JOHN S. HARSHEY, M.D.
22e. ADDRESS: 8 Church St. Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4-7-69	Church of Brethren C,	Rocky Ridge Fred, Co. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Raymond E. Creager	Raymond E. Creager Thurmont, Md.	APR 8 1969	Glenn L. Bowers

VR A15 (4)
30M REV 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05286

CERTIFICATE OF DEATH

05278

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Essie	E.	Keymann	4	11	69	10 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	4/15/80	88 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Switzerland	U.S.A	WIDOWED ☒	CARROLL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
SYKESVILLE	PULLEN Nsg. Home	Housewife	

13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	—	Baltimore	YES ☒ NO ☐	2911 Westfield Ave

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Joseph		Henggeler	Anna		Maria

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	215-01-4922	Mr M Alphons Reymann	Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Several days
DUE TO, OR AS A CONSEQUENCE OF (b)	Generalized Arteriosclerosis	2-3 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)	Terminal Pneumonia	5 days.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, OR CONDITION GIVEN IN PART I(a)

Hemiplegia Rt. Cer. Bram Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from June 14, 1965, to 4.11, 1969, that (I) (we) last saw the deceased alive on 4.10 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Sani Ekutman		☒	☐	☐	4.11.69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Sani Ekutman	Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/14/69	Holy Redeemer	Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Leonard J Ruck Inc. Baltimore, Maryland	APR 14 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05287 05279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
30M REV 1/68

1 DECEASED-NAME (Type or print): First Harry Middle Wilson Last Sarver

2a DATE OF DEATH: Month April Day 6 Year 69

2b HOUR: 7:30 P.M.

3. SEX: Male

4. RACE: White

5 DATE OF BIRTH: Nov 2 1881

6 AGE (In years last birthday): 87 YRS

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN

7a. BIRTHPLACE (State or foreign country): Somerset Pa

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Carroll Md.

10 CITY OR TOWN OF DEATH: Westminster RFD3

11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): (Rural)

12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): State Highway Dept

12b KIND OF BUSINESS OR INDUSTRY:

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Pa

13b COUNTY: Somerset Co

13c CITY OR TOWN: Berlin Pa

13d INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET AND NUMBER: 1506 E. Main St

14. FATHER'S NAME First John Middle Last Sarver

15. MOTHER'S MAIDEN NAME First Matilda Middle Last Flamm

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 161-18-5800

17 INFORMANT: Mrs Mabel Shaffer Address: Westminster Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease — 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a AUTOPSY? YES ☐ NO ☑

20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Oct, 1967, to April 6, 1969, that (I) (we) last saw the deceased alive on April 2 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death

22b. SIGNATURE: W. H Foard M.D. DEGREE — ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 4/6/69

22d. PHYSICIAN'S NAME (Type): W. H Foard M.D

22e. ADDRESS: Manchester Md 21102

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 4/9/69

23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F Cemetery

23d. LOCATION (City or Town) (County) (State): Berlin Pa.

24 FUNERAL DIRECTOR: J. E. Myers Jr. ADDRESS: Westminster, Md

25a. REC'D BY REGISTRAR DATE: APR 10 1969

25b REGISTRAR'S SIGNATURE: Miriam Dodge

1

05288

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05280

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
TRUMAN	WILSON	SAUBLE	4	27	69	3:37 M

3. SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
MALE	WHITE	JAN. 3, 1894	75 YRS				

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		CARROLL CO. Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
WESTMINSTER	CARROLL CO. GEN. HOSP.	TRUCK DRIVER	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET AND NUMBER
MARYLAND	CARROLL	WESTMINSTER		8 MAPLE AVE.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
WESLEY	E.	SAUBLE	IRENE		KOONTZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service,	16b SOCIAL SECURITY NO	17 INFORMANT Address
NO —	217-01-7284	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: IMMED.

DUE TO, OR AS A CONSEQUENCE OF

(b) ATHEROSCLEROTIC CORONARY HEART DISEASE — YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DIABETES MELLITUS

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 4/18, 1969, to 4/27, 1969, that (I) (we) last saw the deceased alive on 4/27 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED
Vincent J. Lucas M.D.		4/27/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	4/30/69	ST. JOHN'S CEMETERY	WESTMINSTER, MD.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
J. E. Myers Jr.	Westminster, Md.	MAY 2 1969	Charles Yingling

VR A1S 45M 1 69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05289 — 05281

1. DECEASED-NAME (Type or print)	First: Effie	Middle: Ray	Last: Senseney ~~Sensersky~~
2a. DATE OF DEATH	Month: April	Day: 4	Year: 1969
2b. HOUR	7:30 PM		
3. SEX	Female		
4. RACE	White		
5. DATE OF BIRTH	October 23, 1874		
6. AGE (In years last birthday)	94 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	Maryland		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐			
9. COUNTY OF DEATH	Carroll Md.		
10. CITY OR TOWN OF DEATH	Union Bridge		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Route # 1		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	Housewife		
12b. KIND OF BUSINESS OR INDUSTRY	Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland		
13b. COUNTY	Carroll		
13c. CITY OR TOWN	Union Bridge		
13d. INSIDE CITY LIMITS? YES ☐ NO ☒			
13e. STREET AND NUMBER	Route # 1		
14. FATHER'S NAME First / Middle / Last	Manassa		Repp
15. MOTHER'S MAIDEN NAME First / Middle / Last	Elizabeth		Pfoutz
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	No		
16b. SOCIAL SECURITY NO	None		
17. INFORMANT Address	Mr. Marshall Senseney, Union Bridge, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Atherosclerotic Heart Disease — APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH: Years

4 1 9 3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Cerebral Atherosclerosis ; Hypostatic Pneumonia .

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 1963, 19____, to April 4, 1969, that (I) (~~me~~) last saw the deceased alive on April 4 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~me~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE, DEGREE	J.H. Caricofe M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: April 4, 1969
22d. PHYSICIAN'S NAME (Type)	J.H.Caricofe	22e. ADDRESS	Union Bridge, Maryland 21791

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	April 8, 1969	Pipe Creek Cemetery	Uniontown, Carroll Co., Md.	
24. FUNERAL DIRECTOR	C.O.Fuss & Son	ADDRESS	Taneytown, Maryland	25a. REC'D BY REGISTRAR DATE: APR 7 1969
	John H. Stiles			25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05290 0528

1. DECEASED-NAME (Type or print): First EDNA Middle MAY Last SMITH
2a. DATE OF DEATH: Month April Day 23 Year 1969
2b. HOUR: 2 A M
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: OCT. 16-1885
6. AGE (In years last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: CARROLL Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 319 E. MAIN ST
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEKEEPING
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: CARROLL
13c. CITY OR TOWN: WESTMINSTER
13d. INSIDE CITY LIM.TS? YES ☒ NO ☐
13e. STREET AND NUMBER: 319 E. MAIN ST.
14. FATHER'S NAME First HARRY Middle SMITH Last
15. MOTHER'S MAIDEN NAME First SALLY Middle SHUEY Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service): No
16b. SOCIAL SECURITY NO: 213-38-8648
17. INFORMANT: MYRTLE S. SMITH Address: 3 E. MAIN ST WESTMINSTER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: undetermined

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes, arteriosclerosis, senility.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 1949, 19____, to 4/23/69, 19____, that (I) ~~(we)~~ last saw the deceased alive on 4/3/69 19____, and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: M.E. Robertson MD DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 4/23/69
22d. PHYSICIAN'S NAME (Type): M.E. ROBERTSON
22e. ADDRESS: New Windsor Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 4-25-69
23c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK CEM
23d. LOCATION (City or Town): (County): CARROLL COUNTY (State): MD
24. FUNERAL DIRECTOR: D.D. Hutter & Sons ADDRESS: New Windsor MD
25a. RECD BY REGISTRAR DATE: APR 24 1969
25b. REGISTRAR'S SIGNATURE: Wilmer Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1768

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, but the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-68)
45M - 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05291 — 05283

1. DECEASED-NAME (Type or print) First: Lottie	Middle: Barron	Last: Smith	2a. DATE OF DEATH Month: 4	Day: 4	Year: 69	2b. HOUR: 935P
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 7-13-1870	6. AGE (In years last birthday): 98 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll			Md
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home			
13a. USUAL RESIDENCE (Where deceased lived; if institution Residence before admission) STATE: Maryland	13b. COUNTY: Balto. City	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 808 Madison Ave.		
14. FATHER'S NAME First: Jacob	Middle:	Last: Strub	15. MOTHER'S MAIDEN NAME First: Sally	Middle:	Last: Wilkerson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 220-54-662 2	17. INFORMANT: Springfield Hosp. Records	Address: Sykesville Maryland		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bilateral Bronchopneumonia — Approximate interval between onset and death: Days

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerotic heart disease — Years

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

Chronic Brain Syndrome, Asso. with cerebral arteriosclerosis without psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 7-20-62, 19__, to 4-4-69, 19__, that (I) (we) last saw the deceased alive on 4-4-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒	22c. DATE SIGNED
Manuel V. Patricio		4-4-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
GRACIO V. PATRICIO	Springfield State Hosp. Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4-8-69	Woodlawn	Woodlawn Baltimore Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John T. Stansbury, Sr. - 641	Windsor Mill Rd.	DATE APR 7 1969	J. Charles Judge

2 1

05292

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05284

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b. HOUR
CECIL	WALDO	SMOOT	APRIL 22, 1969	11:00 A M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Male	White	10-9-16	52 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Virginia	U.S.A.		Carroll Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Odd Jobs	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES ☐ NO ☐	13e STREET AND NUMBER
Maryland	Montgomery	See across		NO FIXED ADDRESS

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Samuel	O.	Smoot	Mary	M.	Williams

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
No	Unk.	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Massive hemorrhage of left jugular vein	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Erosion of vein by carcinoma	Minutes
DUE TO, OR AS A CONSEQUENCE OF (c)	Extensive carcinoma of central & left side of neck	Months

1957

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 10-2-68, 19____, to 4-22-69, 19____, that (I) (we) last saw the deceased alive on 4-22-69 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS ☒	22c. DATE SIGNED
Octavio A Ruiz MD					4-22-69

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
Octavio A. Ruiz, M. D.	Springfield State Hospital Sykesville, Maryland 21784

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4/24/69	Fort Kineo Cem.	Bladensburg Rt Md

24. FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
W.W. Chambers, Inc	8655 Georgia Ave Silver Spring Md	APR 28 1969	Attorney, Judge

VR A15 12
45M 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05293

CERTIFICATE OF DEATH

05285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print): First ~~Xxxxx~~ Mary; Middle ~~Xxxx~~ Marie; Last Springirth

2a. DATE OF DEATH: 4 Month 15 Day 69 Year

2b HOUR: 7:45 am M

3 SEX: female

4. RACE: white

5. DATE OF BIRTH: 11/19/98

6. AGE (In years last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (State or foreign country): West Virginia

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Carroll Md

10. CITY OR TOWN OF DEATH: Rural--Sykesville

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): housewife

12b. KIND OF BUSINESS OR INDUSTRY: own home

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.

13b. COUNTY: Montgomery

13c. CITY OR TOWN: Kensington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 3700 Farragut Street

14. FATHER'S NAME First: Charles Middle: Menear ~~Xxxxx~~ Last:

15. MOTHER'S MAIDEN NAME First: Agnes Middle: - Last: Oats ~~Xxxx~~

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16b. SOCIAL SECURITY NO: none

17. INFORMANT: Carl B. Springirth Address: 3700 Farragut St Kensington, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

4270

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Depressive reaction

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING ETC)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that ~~X~~ (this hospital) attended the deceased from 1/19/ , 19 65 , to 4/15/ , 19 69 , that ~~X~~ (we) last saw the deceased alive on 4/15/ 1969 , and that in ~~X~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~X~~ (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE (DEGREE): Naci N. Buyukunsal, M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22c. DATE SIGNED: 4/15/69

22d. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M.D.

22e. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: April 18, 1969

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.

23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: C. Glen Carter ADDRESS: 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. RECD BY REGISTRAR DATE: APR 21 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 74
45M 1/74

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05294 05286

1 DECEASED-NAME (Type or print) First: Emma	Middle: J.	Last: Study	2a. DATE OF DEATH Month: April Day: 28 Year: 1969
2b. HOUR: 6:30 A M			
3 SEX: Female	4 RACE: White	5. DATE OF BIRTH: 6/28/1898	6 AGE (In years last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): Carroll Co. Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.
10 CITY OR TOWN OF DEATH: Mailing Address Nr. Taneytown Md.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Littlestown, Pa. R.D.1	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife-Housework	12b. KIND OF BUSINESS OR INDUSTRY: Own home
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b COUNTY: Carroll	13c. CITY OR TOWN: Near Taneytown	13d INSIDE CITY LIMITS? YES ☐ NO ☒
13e STREET AND NUMBER: Mailing Address Littlestown, Pa. R. D. 1			
14 FATHER'S NAME First: Henry	Middle: —	Last: Messinger	15. MOTHER'S MAIDEN NAME First: Eliza Middle: — Last: Unger
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 218-22-8057	17. INFORMANT Address: Ralph W. Study, Littlestown, Pa. R. D. 1	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	① Hypertensive Heart disease with	2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (b) ② Uterine Fibroma Senile Cystitis.	5 yrs
	DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus	Long

1909

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Nephritis Chronic.

19a DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (this hospital) attended the deceased from Oct., 19 62, to April 28, 19 69, that (I) (we) last saw the deceased alive on April 26 19 69, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (~~did~~) (did not) view the body after death.

22b SIGNATURE: George E Thomassy M.D.	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 4.28.69	
22d. PHYSICIAN'S NAME (Type): George E Thomassy	22e. ADDRESS: Hanover Pa		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 5/1/69 ~~4/30/69~~	23c NAME OF CEMETERY OR CREMATORY: Christ Church Cemetery	23d. LOCATION (City or Town) (County) (State): Nr. Littlestown, Adams Co. Pa.	
24. FUNERAL DIRECTOR: Richard A. Little	ADDRESS: Littlestown, Pa.	25a. REC'D BY REGISTRAR DATE: MAY 1 1969	25b. REGISTRAR'S SIGNATURE: Kenneth Snyder	

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05295 05287

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First Middle Last: George Herman VON DREELE		2a. DATE OF DEATH Month Day Year: April 11, 1969	2b. HOUR: 11:30 P.M.
3. SEX: male	4. RACE: white	5. DATE OF BIRTH: 11-2-92	6. AGE (In years last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): none	12b. KIND OF BUSINESS OR INDUSTRY: none
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: —	13c. CITY OR TOWN: Balto.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 1200 Valley St.			
14. FATHER'S NAME First Middle Last: John H. Von Dreele		15. MOTHER'S MAIDEN NAME First Middle Last: Katherine Lehr	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Records Address: Springfield State Hospital, Sykesville, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	4 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestive Heart Failure	months
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Heart Disease	years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CBS with cerebral arteriosclerosis with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (this hospital) attended the deceased from 8-5-63, 19____, to 4-11-69, 19____, that (I) (we) last saw the deceased alive on 4-11-69, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Gracito V. Patricio DEGREE	ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐	22c. DATE SIGNED: 4/11/69	
22d. PHYSICIAN'S NAME (Type): GRACITO V. PATRICIO	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/14/69	23c. NAME OF CEMETERY OR CREMATORY: Loudon Park	23d. LOCATION (City or Town): Baltimore	(County) (State): Md.
24. FUNERAL DIRECTOR: Henry W. Jenkins	ADDRESS: 4505 York Rd. Balto. 12, Md.	25a. RECD BY REGISTRAR DATE: APR 14 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (A) 45M - 1-68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 19 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05296

CERTIFICATE OF DEATH

05288

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
George	R. E.	Weitzel	April	29	1969	10:30 AM

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / M.N
Male	White	Feb. 12, 1898	71 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Unknown			Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Woodbine		Nursing Home Owner-retired	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Carroll	Woodbine	YES ☒ NO ☐	

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Unknown			Unknown		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		216-05-1159	James A. Hall, Box 299, Rt. 4	Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Thrombosis, ASHD, Arteriosclerosis, — APPROX. INTERVAL BETWEEN ONSET AND DEATH: 1960

DUE TO, OR AS A CONSEQUENCE OF (b) generalized, questionable abdominal aneurysm. — April 1969

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 1968, 19—, to April, 19 69, that (I) (we) last saw the deceased alive on April 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Howard E Hall					4/29/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Howard E. Hall, M. D.	College Ave. Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/2/1969	Good Sheppard	Howard, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. M. Waltz, Box 241, Sykesville, Md.		MAY 2 1969	Charles Judge

05297

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05289

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours after death.

VR A (5) (4)
30M REV 1-68

1. DECEASED-NAME (Type or print) First: GLADYS	Middle: MAY	Last: WIMERT	2a. DATE OF DEATH Month: APRIL Day: 27 Year: 1969		2b. HOUR: A M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: AUG. 27, 1900	6. AGE (In years last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): BALTO. MD	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Co. Md.		
10. CITY OR TOWN OF DEATH: WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 67 W. Main St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): NEWSPAPER EXECUTIVE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: MARYLAND	13b. COUNTY: CARROLL CO.	13c. CITY OR TOWN: WESTMINSTER	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: 67 W. MAIN ST	
14. FATHER'S NAME First / Middle / Last: LEWIS N. CHENOWETH		15. MOTHER'S MAIDEN NAME First / Middle / Last: MARY PARSONS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	(If yes give war or dates of service): —	16b. SOCIAL SECURITY NO: 217-01-7204	17. INFORMANT: LESTER WIMERT,	Address: WESTMORELAND ST. WESTMINSTER MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC CARDIOVASCULAR DIS
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from NOV, 19 68, to APRIL, 19 69, that (I) (we) last saw the deceased alive on APRIL 27 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Daniel I. Welliver	DEGREE	ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS. ☐	22c DATE SIGNED: 4-27-69		
22d. PHYSICIAN'S NAME (Type): DANIEL I. WELLIVER MD	22e. ADDRESS: 9 RIDGE ROAD WESTMINSTER MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE: 5/1/69	23c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEMETERY	23d LOCATION (City or Town): WESTMINSTER	(County):	(State): MD.
24. FUNERAL DIRECTOR: L. S. Myers, Jr.	ADDRESS: Westminster, Md.	25a. REC'D BY REGISTRAR DATE: MAY 2 1969	25b. REGISTRAR'S SIGNATURE: Mary Yingling		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05298 05290

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b. HOUR			
PETER		WOLF	4	29	1969	8:30 A.M.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month 4 Day 29 Year 1969	2d. HOUR 10:55 A.M.
Male	White	Nov. 19, 1910	58 YRS.						

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH	
Maryland	U.S.A.		Carroll	Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westminster	R.D. 6	Maintenance	Shoe Factory

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Maryland	Carroll	Westminster		Route 6

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
George		Wolf	Lillie		Nuner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give wars or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 2	219-03-2136	Mrs. Rhoda V. Wolf	Same As #13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
953X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) Suffocation (By Hanging)
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year A.M. P.M. 4/29 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Hanged Self in Cellar of Home	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home	21f. LOCATION—Street or R.F.D. No. RD 6 Medford	City or Town Westminster	County Carroll	State Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural couses ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE W. Glenn Speicher M.D.

EXAMINER'S NAME (Type) Dr. W. Glenn Speicher

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street or city or county) Westminster, Md.

22b. DATE SIGNED 4-29-69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	5/2/1969	Trinity Lutheran	Carroll, Md.	

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. M. Waltz, Box 241, Sykesville, Md.	MAY 2 1969	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05299

05291

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: JOHN	Middle: SUMMERVILLE	Last: YOUNG	2a. DATE OF DEATH Month: APRIL Day: 11 Year: 1969 — 2b. HOUR: 2:00 A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 1-5-07	6. AGE (In years last birthday): 62 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Auto mechanic	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Baltimore City	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET AND NUMBER: 1437 Roland Heights Ave.
14. FATHER'S NAME First: John	Middle: S.	Last: Young, Sr.	15. MOTHER'S MAIDEN NAME First: Nettie	Middle	Last: Baublitz
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 216-10-5415	17. INFORMANT: Records, Springfield State Hospital — Address	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Scleroderma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years
7340
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CBS, other diseases of unknown or uncertain cause (scleroderma), with psychotic reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10-1-65, 19____, to 4-11-69, 19____, that (I) (we) last saw the deceased alive on 4-11-69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dr. Antonius Glahn	DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED: 4/11/69
22d. PHYSICIAN'S NAME (Type): Antonius Glahn, M. D.	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4,14,69	23c. NAME OF CEMETERY OR CREMATORY: Moreland Mem.	23d. LOCATION (City or Town): Balto.	(County): Md. (State):
24. FUNERAL DIRECTOR: Paul E. Chenoweth 3rd.	ADDRESS: 3617 Chestnut Ave.	25a. RECD BY REGISTRAR DATE: APR 15 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

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